Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

Brand-name Antipsychotic
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____Beneficiary's Medicaid #: _____

DOB:_____ City: _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____NPI: _____

City: _____ State: _____ Medicaid ID: _____

Phone: _____ Fax: _____

Injectable antipsychotic medications are intended for administration in a clinic or hospital setting, rather than in the home. As the treating physician, I confirm that this drug is not stocked in my office for Medicaid Beneficiaries or non-Medicaid patients. Further, I confirm that this drug will be delivered to my office by clinic or pharmacy personnel only for administration by a clinical staff member.

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact my subject me to civil penalties, fines or criminal prosecution.

_____ _____
Physician's Signature Date

PHARMACY INFORMATION

Dispensing Pharmacy:_____ Provider ID#:_____

City: _____State:_____ Phone: _____

Fax #:_____

DRUG/CLINICAL INFORMATION

Drug Name & Strength: _____ NDC: _____

Diagnosis:_____

Medical Justification for injectable antipsychotic:

_____

Is this patient receiving oral antipsychotic therapy? ____ Yes ____ No

If yes, indicate the intended duration of oral antipsychotic therapy: _____